Appendix 19

Example of Prior Authorization Amendment Request Form

Wisconsin Medicaid Prior Authorization Request

Mail To:

EDS
Prior Authorization Unit
6406 Bridge Road, Suite 88
Madison, WI 53784-0088

1. Complete this form and attach:
   a. A copy of the original Prior Authorization Request Form.
   b. Updated physician's orders/plan of care.
   c. Home Care Assessment Form OR Update (for PCW requests).
2. Mail to Wisconsin Medicaid.

1) Date: MM/DD/YY	2) Previous Prior Authorization Number: 7654321	
3) Recipient Name: Recipient, Ima A.	4) Recipient Medicaid ID Number: 1234567890	
5) Billing Provider Name and Address: I. M. Billing, 1 W. Williams, Anytown, WI 55555	6) Billing Provider Number: 87654321	7) Amendment Effective Date: FROM: 2/15/99 TO: 5/13/99

8) Reason(s) for Amendment Request:

On 1/15/99, client had a CVA with L sided weakness. She is able to ambulate with a quad cane and is safe alone with Lifeline, but requires more assistance with ADLs. Please see revised relevant assessments.

Request 1 hr/day x 7 days/wk in addition to the hours already provided.

9) Indicate procedure(s) to be amended by hours/visits per day, days per week, multiplied by the number of weeks.

RN _____

LPN _____

HHA _____

PT _____

OT _____

ST _____

PCW W9903 Add 1 hr/day, 7 days/wk X 14 weeks

OTHER W9902 1hr/day TT X 7 days

10) I.M. Requesting, RN (Signature) 02/15/99 (Date)